UNION ENROLLMENT CHANGE REQUEST FORM

Name:

Daytime Phone Number:

Union: ☐ IBEW Local 109 ☐ IUEC Local 2 ☐ IUOE Local 399
☐ IBEW Local 134 ☐ IUEC Local 34 ☐ Sheet Metal Workers Local 73

Change Requested (mark all that apply):

☐ A. Address ☐ C. Payment Method
☐ B. Phone Number ☐ D. Other

A. My new address is:

Street address:

City: State: Zip:

B. My new phone number is:

New Phone Number: (____)_____-_____

C. Please change my payment method as follows:

Charge my premium to a new credit card. (Select Visa or Mastercard)

☐ Visa: _____-_____-_____-_____ exp: ___/___

☐ MC: _____-_____-_____-_____ exp: ___/___

Please do a monthly bank draft. (Select Checking or Savings)

☐ Checking: Routing #_____ Account #_____

☐ Savings: Routing #_____ Account #_____

D. Please make another change:

☐ Please suspend my premium payment effective*:_____

This change is due to: ☐ Unemployment ☐ Disability, illness, or injury

☐ Please reinstate my premium payment effective*:_____

☐ Please cancel my policy effective*:_____

☐ Please update my wage rate to*: _____

☐ Other:_____

Signature:_____ Date:_____

**Premium adjustments are only allowed retroactively up to 60 days. Reinstatements must be requested within 60 days of return to work or a medical questionnaire will be required to rejoin the plan. Wage rate changes will take effect on the first of the month following your request.*

Once complete, fax or mail this form to: Group Benefit Associates 773-427-6875 fax
3963 W. Belmont Ave., Suite 6, Chicago, IL 60618